

6 10 Y

EPSDT
Screening Date

2 0 0

Member
ID#

— — — — —

6 to 10 Year Visit

Name _____ Birth Date _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs Length _____ inches BP _____ Temp. _____ T O

History Update

Changes in your family history? No Yes

Has the patient had any new problems or illnesses since the last visit? No Yes

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Problems / Parental Concerns

Nutrition

Low fat milk ? yes no

Variety of fruits/vegetables? yes no

Eats breakfast? yes no

Eats supper with family? yes no

Hearing

 (test at age 10 or every 5 yrs if nl)

Hearing screen pass fail

Date _____

Vision

 (test every two years)

L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____

☐ Wears glasses, sees eye specialist

School Grade _____

Problems? Yes No

TB Risk Factors* yes no

(see separate form)

IPPD result _____

Lab Tests

Hgb _____

If abnormal or not done at age 5 years.

Cholesterol _____

If risk factors and not done at age 5 yrs.

Urinalysis (If abnl. or not done at 5 yrs.)

see back for results

*see separate form

Physical Exam (UNCLOTHED)	Yes	No	✓ = nl	X = abnl
General	<input type="checkbox"/>			
Head	<input type="checkbox"/>			
Neck	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>			
Ears	<input type="checkbox"/>			
Nose	<input type="checkbox"/>			
Throat/Mouth/Teeth	<input type="checkbox"/>			
Chest	<input type="checkbox"/>			
Breasts/Tanner Stage				
Lungs	<input type="checkbox"/>			
Heart	<input type="checkbox"/>			
Abdomen	<input type="checkbox"/>			
Femoral Pulses	<input type="checkbox"/>			
Genitalia /Tanner Stage				
Female	<input type="checkbox"/>			
Male	<input type="checkbox"/>			
Extremities	<input type="checkbox"/>			
Spine	<input type="checkbox"/>			
Skin	<input type="checkbox"/>			
Neuro	<input type="checkbox"/>			

Safety

☐ Smoke detectors, no smoking in home

☐ Buckle up!

☐ Booster seat < 58", < 70#

☐ Bike helmet, street safety

☐ Water safety, swimming lessons

☐ Firearm safety

☐ Sunburn prevention

Health/Nutrition

☐ Low fat milk and snacks

☐ Encourage fruits and vegetables

☐ Brush teeth, see dentist

☐ Encourage sports, active play

Social/Behavioral

☐ School adjustment, performance

☐ Sports and hobbies

☐ Limit TV, computer games

☐ Give choices, encourage independence

☐ Set limits, provide consequences

☐ Privacy, personal hygiene

☐ Puberty changes and ? about sex

☐ Family relationships

☐ Friends and schoolmates

☐ Dealing with strangers

☐ Developmental/Behavioral

Screen*

Provider ID#

Impression

☐ Well Child, normal growth and development

☐ _____

☐ _____

Plan/Referrals

☐ Immunizations current yes no

☐ RTC at _____ years

☐ See dentist _____

☐ Handouts _____

☐ _____

☐ _____

☐ _____

☐ _____

M.D. / P.N.P.

☐ See back for additional documentation
